STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185257	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green River Trails	213 Industrial Road Greensburg, KY 42743

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50491 Based on observation, interview, record review, and review of facility's policies, it was determined the facility failed to provide a safe, clean, comfortable and homelike environment for its residents. Observation revealed the facility failed to provide a safe, clean comfortable and homelike environment for it's residents, as evidenced by insufficient upkeep of the physical environment. The findings include: Review of the facility's policy titled, Cleaning and Disinfecting Resident's Rooms, dated August 2013, revealed the facility would ensure environmental surfaces were disinfected (or cleaned) on a regular basis (e. g., daily, three times per week) and when surfaces were visibly soiled. Further review revealed curtains in resident areas were to be cleaned when the surfaces were visibly contaminated or soiled. Review of the facility's policy titled, Cleaning and Disinfection of Resident-Care Items and Equipment, dated September 2022, revealed the facility was to ensure non-critical items such as bed rails, bedside tables, etc. (e.g., curtains) that might meet intact (resident) skin, but not mucous membranes were to be cleaned and disinfected according to current Centers for Disease Control (CDC) recommendations. Review of the facility's April 2024 Monthly Meeting Report regarding cleaning schedule for the facility including: the floors, kick plates, linens, hallways, and quality control. The report revealed Kick plates had been scrubbed to the best of our ability. However, even with the strongest products we have, they remain stained. Further review of the Monthly Meeting Report revealed repairs to the kick plates recommended to administrator that they be painted or replaced. Review of the Maintenance (personnel's) job description dated December 2009, revealed the Maintenance Department was responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. Continued review revealed the Maintenance Department was to be under the direct supervision of the facility's Assistant Administrator. Further review revealed the Maintenance Department was responsible for maintaining the building in good repair and free from hazards. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's Quality Control Inspection Housekeeping log dated April 2024, revealed the vents were to be cleaned. Housekeeping logs was filled in with the rooms cleaned and the vents and air conditioning units were listed on the cleaning list. Items completed were initialed. Observation on 05/21/2024 at 1:00 PM. revealed yellow-brown stains on four floor tiles and cracked ceiling tiles around the circular vent, in front of resident room [ROOM NUMBER]. Continued observation revealed heavy dust particles on two output vents near resident room [ROOM NUMBER] and a sticky substance on the door frame of that room. Observation on 05/21/2024 at 1:30 PM, revealed flies in the hallway during lunch time. Continued observation revealed loose brown dirt in corners of the entrance door at resident room [ROOM NUMBER]. Observation on 05/21/2024 at 1:33 PM, revealed a marred, blackish gray dirty kick-plate on the resident bath shower entrance door, next to resident room [ROOM NUMBER]. Observation on 05/21/24 at 4:38 PM, revealed resident room [ROOM NUMBER]-B's sheets with brown stains and food particles covering the bolster mattress on the bed. Observation on 05/21/24 at 4:40 PM, revealed brown/yellowish stain coloring on floors at edges between rooms one and two on the facility's north hall and some loose baseboards in the nearby hallway. Observation on 05/21/2024 5:10 PM, of resident room [ROOM NUMBER] of Resident (R) 58's bed, revealed a heavily soiled privacy/divider curtain with multiple large brown stains on it. Observation on 05/21/2024 at 1:35 PM, revealed inside resident room [ROOM NUMBER]-2, an empty Mountain Dew soda can lying on the floor, in the walkway path. Continued observation revealed a gap, on the corner of a vent cover between the vent cover and the painted drywall, located just inside the entrance door to room [ROOM NUMBER], on the left. Further observation revealed a loose plug-in cover on wall, which created about a, 1/8-inch gap, along the top of the plug-in cover. Additionally, observation revealed marring approximately 4 inch long, dark grayish, black markings resembling scrape/scuff marks on the door and marring blackish linear scrape markings on wall. Observation on 05/21/2024 at 1:00 PM, residents' room [ROOM NUMBER] and room [ROOM NUMBER] revealed brown tan colored lint hanging from vents in the bathroom. Observation of resident room [ROOM NUMBER] on 05/21/2024 at 1:04 PM, revealed the privacy curtain separating the beds had a brown substance on the bottom of the curtain, and the curtain was stained in multiple spots with dark brownish unknown substance. Further observation revealed the residents' bathroom had a strong urine scent detectable. Observation on 05/22/2024 at 9:00 AM, revealed resident room [ROOM NUMBER] had a small brown stain on the privacy curtain. Observation on 05/22/2024 at 4:19 PM, revealed the same two dust filled ceiling outlet vents on each side of resident room [ROOM NUMBER]. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of resident room [ROOM NUMBER]-2 on 05/24/2024 at 12:00 PM, revealed the room curtains had two soiled areas; one almost inch long area noted approximately shoulder high on the curtain, with a small round soiled area about 2 inches from the larger area. Further observation revealed brownish soiled areas approximately 4 feet up on the divider curtains. Observation of resident room [ROOM NUMBER] on 05/24/2024 at 12:05 PM, revealed a divider curtain soiled about three feet up and approximately 12 inches inward from the divider curtain edge. Further observation revealed the soiled areas appeared to be a dripping, linear dark brown/black substance. Review of R21's Admission Record revealed the facility admitted the resident on 04/07/2023, with diagnoses of unspecified atrial fibrillation, chronic obstructive pulmonary disease, type 2 diabetes mellitus, bipolar disorder, major depressive disorder, and generalized anxiety disorder. Review of R21's Annual Minimum Data Set (MDS) Assessment, dated 04/11/2024, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated R21 was cognitively intact. During an interview on 05/21/2024 at 4:15 PM, R21 in room [ROOM NUMBER]-1 stated he could not remember the last time the privacy curtain in his room had been taken down and washed and cleaned. R21 stated the privacy curtain had those same stains ever since he had been living in the room, and the brown substance had been on there for at least a month. Review of R21's Admission Record revealed the facility admitted the resident on 04/07/2023, with diagnoses of unspecified atrial fibrillation, chronic obstructive pulmonary disease, type 2 diabetes mellitus, bipolar disorder, major depressive disorder, and generalized anxiety disorder. Review of R21's Annual Minimum Data Set (MDS) Assessment, dated 04/11/2024, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated R21 was cognitively intact. During an interview with R13 on 05/21/2024 at 4:30 PM, room [ROOM NUMBER]-2 he stated housekeeping cleaned the residents' bathroom daily, but the urine scent was always still there. R13 stated the brown substance had been on the privacy curtain for a few weeks and he was not sure what the substance was. The resident stated the privacy curtain had the stained spots on it for as long as he had been living in the facility. During an interview with Housekeeping/Sanitation (H/S) 1 revealed she had a routine when cleaning the residents' rooms. H/S 1 stated her routine is to dust the rooms first, then sweep and mop last. She stated a pre-mixed cleaner was used for the floors, another cleaner used for the bathroom and a different one used for odors. H/S 1 stated a duster was used for high areas such as the top of the TV. She added, one cleaning rag is was used per room to avoid any contamination of other areas, and garbage containers were emptied daily, sprayed, and lined with new liners. Spoke with H/S 1 concerning dusty tan colored lint hanging form vents and she stated they were not routinely cleaned by housekeeping. Housekeeping does keep a log of the rooms cleaned and cleaning the vents and air conditioning is listed on the worksheet log. She further stated it is was important to clean the dust off the vents to prevent residents from getting sick. She did not state she was trained by the facility, because she is contracted by Health Services. She did not state whether or not she was trained by Health Services. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Maintenance Director 1 on 05/23/2024 at 4:35 PM, he stated he had worked at the facility for two years and only had one assistant. He stated he would change the filters in outlet vents monthly. Moving forward he plans to create a log for each resident room and areas of the facility to ensure filters are changed and vents cleaned. He plans to incorporate the new forms as part of his quality assurance. Maintenance Director #1 stated he did a monthly check of resident rooms to address any areas needing repair, and his process was to do a walk through with a checklist and check for frayed cords, areas that needed painting, walls that might need to be calked. He further stated he would keep a notebook of things he had addressed, but there were not any facility forms or check off sheets that were to be initialed. Maintenance stated he changed filters in each outlet vents monthly. He toured the facility monthly to check for needed repairs. He did not state whether he had received any training upon hire. During an interview with Environmental Services Director (ESD) 1 revealed he was aware some of the resident room divider curtains had stains, paint, and fingernail polish on them, and he would put in a request for new curtains periodically. The ESD stated he had received three or four divider curtains a few months ago, and had hung the curtains. Furthermore, he stated three more had been ordered, but they had been back ordered. He provided an order for the recent purchase order dated May 2024. He did not have a regular process for replacement. He stated he would give the request to [NAME], who ordered them. ESD felt it important to change the diver curtains out routinely. He stated he would try to take about three rooms at a time down and replace with clean curtains and that all diver curtains were replaced monthly with a clean diver curtain. And the ones taken down were then cleaned and used again. Interview on 05/22/2024 at 10:55 AM, with the Administrator revealed he expected resident safety to be an optimum priority and he also wanted to provide for the safety of staff as well. In further interview he stated he expected staff to provide a safe environment for the residents. The Administrator stated he was committed to training staff to work as a team to maintain a safe environment for the residents and for the staff.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 44974 Based on interview, record review, and facility policy review, it was determined the facility failed to develop and implement a Baseline Care Plan for one (1) of thirty five (35) sampled residents (Resident #149). Resident (R) 149 was admitted to the facility from the hospital, where the resident had been treated for a femur fracture. However, the facility failed to implement a Baseline Care Plan for the application of Thromboembolic Deterrent hose (anti-embolism stockings) for R149. The findings include: Review of the facility's, Baseline Care Plan policy revealed the completion and implementation of the Baseline Care Plan within 48 hours was intended to promote continuity of care and communication among nursing home staff; increase resident safety; and safeguard against adverse events that were most likely to occur right after a resident's admission. Further review revealed the facility was also to ensure the resident representative(s) were informed of the initial plan for delivery of care and services by receiving a written summary of the Baseline Care Plan. Review of R149's Admission Record revealed the facility admitted the resident on 05/16/2024, with diagnoses of Fracture of Right Femur, Entercolitis (inflammation in a person's digestive tract), due to Clostridium Difficile (a bacteria that causes diarrhea and inflammation of the colon), and Parkinson's Disease. Review of R149's Baseline Care Plan dated 05/16/2024, revealed the facility had developed a focus for Activities of Daily Living (ADLs) for the resident. Continued review of the ADL focus revealed an intervention for application of TED hose (anti-embolism stockings) on in AM (morning) and off in the PM (evening), initiated on 5/16/2024. Further review revealed on 05/17/2024 an intervention was added for TED hose to be applied to R149's right leg on in AM, and off every HS (bedtime) with a resolved date of 05/17/2024. In addition, review of the Baseline Care Plan revealed on 05/24/2024, an intervention was added for TED hose to be applied to R149's bilateral legs, on in the AM and off every HS. Review of R149's Physician Orders revealed an order dated 05/16/2024, for TED hose to be applied to the resident's right lower extremity every morning and off every evening, which was discontinued on 05/16/2024. Continued review of the Physician Orders revealed on 05/18/2024, an order for a STAT (urgent) Venous Doppler (ultrasound) for edema and discoloration times two days. Further review of R149's Physician Orders revealed a new order dated 05/21/2024, for TED hose to be applied to the residents' legs, put on in the AM and take off at bedtime to prevent swelling of the legs. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R149's Treatment Administration Record (TAR) revealed documentation of TED hose placed on 05/21/2024 in AM and off in PM. Continued review of the TAR revealed on 05/22/2024, it was noted R149 refused the TED hose, and on 05/23/3034, it was documented the resident's TED hose were applied in the AM; and removed in the PM. Observation of R#149 on 05/21/2024 at 4:48 PM revealed no TED hose on Resident #149, legs were in dependent position. Further observation noted swelling of bilateral legs more swollen on the left. The Resident was up in the wheelchair in the dining area in front of the nursing station. Observation on 05/22/2023 at revealed Resident #149 up in wheelchair, legs dependent position, and no TED hose on. More edema and redness than yesterday noted to bilateral lower extremities. Resident with complaints of legs hurting. Observation on 05/23/2024 at revealed Resident up in wheelchair, legs dependent position with black TED hose on bilateral legs Observation on 05/24/2024 at revealed Resident up in wheelchair with white TED hose in place. During an interview on 05/23/2024 at 2:35 PM, with Nurse Practitioner (NP) 1 she stated the order for R149's TED hose was initially placed for the right leg only on his admission on 05/16/2024, because the resident had edema due to his femur repair surgery. NP 1 stated she ordered bilateral TED hose for R149 on 05/21/2024 around 3:00 PM or so, because the resident had edema in both his legs. She stated she had ordered a Venous Doppler study for R149, which had been was negative for thrombus. The NP further stated R149's family brought in some TED hose for the resident a few nights ago. In interview with the Director of Nursing (DON) on 05/24/2024 at 1:10 PM, she stated she had been the facility's DON for over a year. She stated any nurse, Kentucky Medication Aide (KMA), or Certified Nursing Assistant (CNA) could apply residents' TED hose. The DON further stated all the Physician orders were discussed in clinical meetings and the residents' care plans updated at that time. She stated her expectations were for residents' TED hose orders to be placed on their care plan. In an interview on 05/24/2024 at 1:25 PM the Administrator stated his expectation was for the clinical team to handle all clinical matters.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44974 Based on interview, record review, and facility policy review, it was determined the facility failed to ensure residents received care and treatment in accordance with professional standards of practice for one (1) of thirty five (35) sampled residents.) (Resident #149). The facility admitted Resident (R)149 from the hospital post-treatment of a femur fracture. The Physician ordered thrombo-embolic deterrent (TED) hose to R149's right lower extremity every morning and off every evening. The order for the TED hose was changed on 05/21/2024, for the hose to be applied to the resident's bilateral legs. However, the facility failed to implement the Physician's orders and clearly document the TED hose treatment ordered. The findings include: Review of the facility policy titled, Baseline Care Plan dated 05/16/2024, revealed a Baseline Care Plan was to be completed and implemented within 48 hours of a resident's admission to promote continuity of care and communication among nursing home staff. Additionally, review revealed the Baseline Care Plan was also to be completed and implemented to increase resident safety and safeguard against adverse events that were most likely to occur right after admission. The State Survey Agency (SSA) Surveyor requested a facility policy related to TED hose application; however, the facility did not supply a specific policy related to TED hose application. Review of the Admission Record for R149 revealed the facility admitted the resident on 05/16/2024, with diagnoses that included: Parkinson's Disease, Fracture of Right Femur, and Entercolitis (inflammation in a person's digestive tract), due to Clostridium Difficile (a bacteria that causes diarrhea and inflammation of the colon). Review of the admission assessment information dated 05/21/2024, revealed the facility assessed R149 with a Brief Interview for Mental Status (BIMS) score of six out of 15, which indicated the resident was moderately cognitively impaired when admitted to the facility. Review of R#149's Physician Orders revealed an order dated 05/16/2024 for TED hose to the right lower extremity every morning and off every evening, which was discontinued that same date. Continued review of the Physician Orders revealed on 05/18/2024, an order for a STAT (urgent) Venous Doppler for edema, and discoloration times two days. Further review of the Physician Orders revealed another order for TED hose dated 05/21/2024 at 8:00 PM, for the hose to be applied to R149's legs in the AM and taken off at bedtime to prevent swelling of the legs. In addition, review revealed the 05/21/2024 Physician order was discontinued at 8:41 PM on that same date. Further review of Physician revealed the order for TED hose to bilateral legs, on in AM , and off every HS was added on 05/23/2024 (Although the NP stated she had given the verbal order on 05/21/2024 for TED hose to bilateral legs, and did not know why it had been discontinued.) (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Baseline Care Plan for R149 revealed the facility had developed an Activities of Daily Living (ADL) focus initiated on 05/16/2024, for the resident which included an intervention to apply TED hose, on in the morning (AM) and off in the afternoon/evening (PM). Per review of the Baseline Care Plan, on 05/17/2024, an intervention was added for TED hose to be applied to R149's right leg, on in AM, and off every HS (bedtime) which had a resolved date for that same date. Further review revealed an additional intervention was noted on the Baseline Care Plan on 05/24/2024, for TED hose to be applied to R149's bilateral legs, on in the AM and off every HS. Review of the STAT Venous Doppler of the left lower extremity report dated 05/20/2024 revealed a negative exam, with no thrombus noted. During an interview on 05/21/2024 at 5:00 PM, with R149's daughter she stated her mother had requested over the weekend for R149 to have TED hose put on. She stated her mother was told they needed a Physician Order. Review of R149's Treatment Administration Record (TAR) for May 2024, revealed a TED hose was placed on only the resident's right leg in the AM and removed in the PM on 5/17/2024, 05/18/2024, 05/19/2024, 05/21/2024, and 5/23/2024. Continued review of the TAR revealed documentation noting R149 refused the TED hose on 05/22/2024. Further review revealed on 05/23/3034, it was documented R149 had his TED hose were applied to his bilateral legs in the AM as ordered on that date. Review of the Nurse Practitioner's Note dated 05/21/2024, revealed R149's left lower extremity had 2+ pitting edema. (order was already in place for RLE TED hose). Per review, the NP's plan was to apply TED hose to R149's bilateral lower extremities on in the morning and off at bedtime. Further review of the NP Note revealed the NP's plan was also to increase R149's Bumex (diuretic) from 0.5 milligram (mg) to 1 mg. daily. Observation of R149 on 05/21/2024 at 4:48 PM, revealed however, the resident sitting up in a wheelchair, in the dining/lounge area, without his TED hose on either extremity. Further observation revealed R149's legs were hanging down in a dependent position with swelling and mild redness of bilateral legs observed in both legs, more swelling on the left than the right. Observation on 05/22/2023 at 9:35 AM, revealed R149 again sitting up in a wheelchair, legs down in a dependent position with no TED hose on as ordered. Further observation revealed R149 had increased edema and redness since the previous observation on 05/21/2024, to his bilateral lower extremities. Observation also revealed R149 was complaining of his legs hurting. Observation on 05/23/2024 at 9:30 AM, revealed R149 was sitting up in a wheelchair with black TED hose on his bilateral legs. Observation on 05/24/2024 at 9:15 AM revealed Resident up in wheelchair with white TED hose in place, as well as non-skid socks. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In interview on 05/24/2024 at 10:58 AM, Certified Nursing Assistant (CNA) 8 stated the CNA's could put TED hose on for residents in the morning and remove them at night. CNA 8 stated if a resident refused to allow staff to put the TED hose on the CNA's reported that information to the nurse, and then the nurse would try to encourage the resident to allow the TED hose to be put on. The CNA further stated that R149 refused at times to wear his TED hose. In addition, she stated the risk for residents not wearing their TED hose which would allow more swelling and/or cause a blood clot to form. Telephonic (Phone) attempts were made on 05/23/2024 to contact Registered Nurse (RN) 2 who documented R149 refused his TED hose on 05/22/2024; however the attempts were unsuccessful. Phone attempts were made on 05/22/2024 at 4:22 PM, 05/23/2024 at 2:07 PM, and 05/24/2024 at 12:02 PM, to contact LPN #1, the nurse who NP #1 gave the verbal order to for R149's TED hose on 05/21/2024; however, all attempts were unsuccessful. During an interview on 05/23/2024 at 2:35 PM, with Nurse Practitioner (NP) 1 she stated R149's TED hose were initially ordered for the right leg only on admission on 05/16/2024, as the resident had edema related to the femur repair surgery. She stated she ordered the bilateral TED hose on 05/21/2024 around 3:00 PM or so, because R149 had edema in both legs. NP 1 further stated she had ordered a Venous Doppler study for R149, and that was negative for thrombus. The NP also stated the family brought in some TED hose a few nights ago. In interview with RN 1 on 05/24/2024 at 10:32 AM, she stated she had worked at the facility for the past [AGE] years. RN 1 stated Resident 149 refused to wear his TED hose at times, and she had documented the refusals in the computer. She stated nurses or aides could apply TED hose, but the nurse was the one who had to ensure the TED hose was on because that information had to be documented on the TAR. RN 1 stated she could not recall when the order came through for R149's TED hose. She further stated the risk of a resident not wearing their TED hose as ordered could be increased swelling or possible blood clots. In an interview on 05/24/2024 at 11:05 AM, with Unit Manager #1(UM) she stated LPN #1 had put in the order for TED hose to R149's bilateral legs, on 05/21/2024. The UM stated she was not sure why the order had been discontinued that same day. In an interview on 05/24/2024 at 12:04 PM, with R149's spouse she stated she informed staff that R149 was supposed to be wearing TED hose; however, was unable to recall who that staff person was. She stated she was informed that staff would contact the Physician or NP and get an order for TED hose R149. The spouse further stated her grandson had gone out and bought a pair of TED hose for R149 and took those to the facility on [DATE]. In an interview on 05/24/2024 at 12:17 PM, with R149's grandson he stated he bought TED hose for R149 and took them to the facility and placed them on R149 himself on 05/22/2024. The grandson further stated he was not sure of what time of day it had been, but thought it was late evening. In an additional interview on 05/24/2024 at 1:10 PM, NP 1 stated she had given a verbal order on 05/21/2024 to an LPN (LPN 1) for R149's TED hose to be applied to the resident's bilateral legs. She stated however, she was not sure why the order placed in the resident's Electronic Medical Record (EMR) had been discontinued on that same day. She stated she knew LPN 1 applied the TED hose to R149's legs prior to her (NP) leaving the facility late on the evening of 05/21/2024. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In interview with the Director of Nursing (DON) on 05/24/2024 at 1:10 PM, she stated she had been the DON at the facility for over a year. The DON stated any nurse, Kentucky Medication Aide (KMA), or Certified Nursing Assistant (CNA) could apply residents' TED hose. She stated it was the nurses who had the order for TED hose and they received those orders from either the Physician or the NP. The DON stated it was her expectation, if a resident had an order for TED hose, for the resident to have the TED hose applied as ordered. She stated if the NP gave an order, whether it was a written order or a verbal order, it was her expectation for those orders to be followed. The DON stated nurses were the ones who documented on the TAR whether residents were wearing their TED hose. She said the nurses placed that information into the facility's computer system when the TED hose were applied in the morning and to taken off at bedtime. The DON stated nurses were ultimately responsible for doing rounds to ensure residents had their TED hose either on or off for the day. She stated if a resident refused to wear their TED hose, then the nurse was to document the refusal and notify the doctor and the family so they were aware of the refusal. The DON further stated all Physician orders were discussed in clinical meetings and the residents' care plans were updated at that time. She further stated she expected residents' TED hose orders to be on a care plan. In interview on 05/24/2024 at 1:45 PM, Physical Therapist (PT) 1 stated when she performed R149's evaluation on 05/17/2024, the resident did not have TED hose on. She stated she recalled that information because she had to find R149 some clothes as he only had pajamas to wear until his family brought more clothes in for him. PT 1 further stated she had provided therapy for R149 on 05/22/2024 around 11:00 AM, and recalled the resident did not have on TED hose at that time either.

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	185257	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green River Trails	213 Industrial Road Greensburg, KY 42743

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50671 Based on observation, interview, and facility policy review, it was determined the facility failed to ensure its dietary staff provided proper hand hygiene in accordance with professional standards for food service safety. Observation revealed a Dietary Aide (DA) washed his hands; however, failed to dry his hands before putting away clean dishes. The findings include: Review of the facility's policy titled, Handwashing/Hand Hygiene, dated August 2019, revealed all personnel should be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. Further policy review revealed all personnel should follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. Observation during the initial tour of the kitchen on 05/21/2024 at 11:00 AM, revealed DA 1 placed dirty dishes on the dish racks to run through the dishwasher. Continued observation revealed DA 1 washed and rinsed his hands in the sink, shook the water off his hands; however, failed to dry his hands. Further observation revealed DA 1 then began to process and put away the clean dishes on the clean side of the dishwasher rack with his wet hands. During an interview with DA 1 on 05/21/2024 at 11:30 AM, he stated at one time there had been a paper towel dispenser on the wall for staff to use; however, the dispenser was removed to repair the wall and was never replaced. The DA stated he could not remember how long it had been gone. He stated he had been in-serviced by the Dietary Manager on proper handwashing and further stated he should have dried his hands thoroughly prior to handling the clean dishes. During an interview with the Dietary Manager on 05/21/2024 at 12:00 PM, she stated the facility had repaired the wall in the kitchen and removed the paper towel dispenser about a year ago, but failed to put the dispenser back up for staff use. She further stated the importance of washing and drying hands between handling clean/dry dishes was to prevent cross-contamination and spread of infections to other personnel, staff, and residents.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49360 Based on observation, interview, and facility policy review, the facility failed to maintain an infection prevention and control program designed to provide a safe and sanitary environment and to help prevent the development and transmission of communicable diseases and infections for three of 10 sampled residents (Residents [R] 4, 15, and 38). The findings include: Review of the facility's policy titled, Policies and Practices--Infection Control, revised October 2018, revealed the facility's infection control policies and practices were intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections. Review of the facility's policy titled, Enhanced Barrier Precautions, revised August 2022, revealed standard precautions applied to the care of all residents regardless of suspected or confirmed infection or colonization status. 1. Review of R4's Face Sheet revealed the facility admitted the resident on 01/06/2016, with admitting diagnoses to include: spina bifida, major depressive disorder, generalized anxiety disorder, and other seizures. Review of R4's Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated intact cognition. Review of R4's Comprehensive Care Plan (CCP) dated 01/06/2016, revealed the facility care planned the resident as at risk for an alteration in respiratory status related to shortness of breath with a goal for oxygen saturation to remain above 90%. Continued review of the CCP revealed the interventions included: administration of oxygen as ordered by the physician; monitor oxygen saturations on room air and/or oxygen; and apply bilevel positive airway pressure (BiPap, a machine used to help with breathing) at bedtime and remove in the mornings. Review of R4's Physician Orders dated April 2023, revealed R4 had been on oxygen at two liters per minute (2 LPM) per nasal cannula (NC) during the night with BiPap therapy. Continued review of the Physician Orders revealed R4 had BiPap orders with settings of minimum 18, maximum 22 centimeters (cm) with oxygen liter flow of 2 LPM every night and the BiPap was to be removed every morning. Observation of R4's room on 05/21/2024 at 1:31 PM, revealed undated oxygen tubing lying on the bed with no barrier covering it. Continued observation revealed undated BiPap tubing was lying next to the uncovered BiPap machine and not in the bag, which was lying on the opposite side of the machine from the tubing. Further observation revealed the oxygen concentrator filter was noted to have dust on it. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of R4's room on 05/22/2024 at 11:44 AM, revealed undated oxygen tubing lying uncovered on top of the oxygen concentrator uncovered. Continued observation revealed the BiPap tubing was lying uncovered on the shelf next to the BiPap machine, and the oxygen concentrator filter continued to have dust on it. In interview with R4 on 05/21/2024 at 5:15 PM, she stated she wore her BiPap during the night for sleep apnea and oxygen at 2 LPM per NC ran through the machine at that time. R4 stated it had been about three weeks since her BiPap tubing had been changed and she was not sure when the last time her oxygen tubing had been changed. The Resident stated when staff removed her BiPap mask in the morning, they would just throw it up on the shelf and she never saw them put the mask in a bag. R4 stated staff would put her oxygen tubing either on top of the machine or on the bed once she got up for the day. She stated staff rarely covered or placed her oxygen tubing in a bag. R4 further stated staff did not clean the filter on her oxygen concentrator when they did change out the oxygen tubing and she was not sure when the last time the filter had been cleaned. 2. Review of the R 15's Face Sheet revealed the facility admitted the resident on 11/20/2021, with admitting diagnoses to include: emphysema, mild cognitive impairment of unknown etiology, unspecified depression, and unspecified persistent mood affective disorder. Review of R 15's Annual MDS assessment dated [DATE], revealed the resident had a BIMS score of 15 out of 15, which indicated intact cognition. Continued review of the MDS revealed R 15's was on oxygen therapy during the night. Review of R 15's CCP dated 12/03/2021, revealed the facility had care planned the resident for altered respiratory status related to emphysema with a goal for oxygen saturations to remain above 90% through the next review date. Continued review of the CCP revealed R 15's had interventions for: oxygen at 3 LPM via a NC every night with monitoring of oxygen saturation every shift; staff to cleanse the BiPap mask and tubing with warm soapy water and rinse weekly and air dry; and to keep the resident's head of bed elevated to prevent shortness of breath. Observation of R 15's room on 05/21/2024 at 1:10 PM, revealed a continuous positive airway pressure (C-PAP) machine sitting on the shelf above the bed with the tubing hanging from the machine with the open end of the C-PAP flex tubing lying on the floor. 3. Review of R 38's Face Sheet revealed the facility admitted the resident on 12/09/2020, with admitting diagnoses to include unspecified dementia, generalized anxiety disorder, other specified depressive episodes, and unspecified dyspnea. Review of R 38's Quarterly MDS assessment dated [DATE], revealed the facility care planned the resident to have a BIMS score of three out of 15, which indicated severe cognitive impairment. Review of R 38's CCP dated 02/24/2024, revealed the facility care planned the resident for altered respiratory status/difficulty breathing related to low oxygen saturation; experiencing shortness of breath with exertion and if attempted to lie flat, with a goal for pulse oximetry to remain above 90% through the next review date. Continued review of the CCP revealed the interventions included: to administer medications as ordered by the physician; monitor for signs and symptoms of respiratory distress and report to the physician as needed; and for the resident to wear oxygen at 2 LPM via a NC as needed. (continued on next page)

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	185257	A. Building B. Wing	05/24/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R 38's physician's orders dated February 2024, revealed an order for oxygen at 2 LPM via a NC as needed to keep oxygen saturation above 90%. Observation of R 38's room on 05/21/2024 at 2:55 PM, revealed undated oxygen tubing lying on the floor next to the resident's bed. Further observation revealed the oxygen concentrator filter appeared dusty. Observation of R 38's room on 05/22/2024 at 9:30 AM, revealed undated oxygen tubing lying on top of the oxygen concentrator uncovered and the oxygen concentrator filter continued to appear dusty. In interview with Kentucky Medication Aide (KMA) 1 on 05/21/2024 at 5:05 PM, she stated any oxygen tubing or BiPap tubing should have been stored in a bag and the tubing was to be changed weekly. KMA #1 stated she was not sure when the oxygen concentrator filters were to be cleaned. She stated the tubing's were to be placed in a bag when not in use to prevent the spread of infections. In interview, the KMA stated she had seen tubing not stored appropriately in bags in the past, but she always disposed of it and got new tubing for those residents, which she date. KMA #1 stated the risk to the residents, wearing the tubing after it was left uncovered and/or lying on the floor, was for an infection which could get into the lungs from the unprotected tubing and possibly cause pneumonia in the residents. In interview with Licensed Practical Nurse (LPN) 1 on 05/21/2024 at 5:20 PM, she stated the oxygen, BiPap and C-PAP tubing, once removed from off the residents, were to be placed in a bag to protect the residents from the spread of infection. LPN 1 stated the tubing was to be thrown away after it had been found lying unprotected and new tubing was to be obtained for the resident, and dated and placed in a bag for future usage. LPN 1 stated she made random rounds during the week to follow up with residents and would spot check to ensure respiratory tubing was dated and stored appropriately. She stated if she saw tubing not stored properly, she threw it away and obtained new tubing which she dated. LPN 1 further stated the risk to residents using dirty tubing was an increased risk for infections such as pneumonia. In interview with the facility's contract supplier Manager for respiratory items on 05/23/2024 at 10:15 AM, he stated his company was contracted to provide equipment and to do routine maintenance on the oxygen equipment as needed. The contract supplier Manager stated their personnel were required to do a walk through in the facility once a month to identify any issues, but they usually came in routinely on a weekly basis and addressed any issues. He stated the facility contracted with a specialty medical services (SMS) provided for a Respiratory Therapist (RT) to provide cleaning of the BiPap and C-PAP machines. The contract supplier Manager stated the RT also was responsible for keeping the tubing clean. He stated it was the facility staff who were responsible for cleaning the oxygen tubing and filters and the contract RT staff kept the BiPap and C-PAP tubing cleaned during their visits to the facility. The contract supplier Manager stated it ultimately fell on the facility's nursing staff to change any oxygen tubing, BiPap or C-PAP tubing for issues like tubing lying on the floor or lying unprotected in the resident's rooms. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In interview with the Admissions Coordinator (AC) on 05/24/2024 at 10:05 AM, she stated she had worked as a Registered Nurse (RN) in the building for the past five years, but for the last year, she had worked as the AC for the facility. She stated any respiratory tubing was to be kept in a bag and labeled with a date for when the tubing had been changed, which was to occur weekly. The AC stated any respiratory tubing lying in a resident's room uncovered was to be thrown away and newly dated tubing provided which was to be placed in a bag. She further stated the risk for residents wearing tubing not stored properly would be the residents breathing in contaminates, which would lead to infections. In interview with Unit Manager (UM) #1 on 05/24/2024 at 10:18 AM, she stated any oxygen tubing, BiPap or C-PAP tubing not in use was to be placed in a bag to prevent the spread of infection. UM #1 stated any unprotected tubing used placed residents at risk for increased infections such as pneumonia or staph infections. She stated those infections could lead to hospitalization s for the residents and require antibiotic therapies. UM 1 stated the facility contracted a respiratory company to come in weekly to change out respiratory tubing. She stated nurses made rounds daily to ensure residents were wearing their oxygen per the Physician orders and to ensure any tubing not in use was stored properly in a bag. UM 1 further stated it was the nurses responsibility to ensure tubing was stored appropriately in a bag when not in use and to dispose of tubing not in bags, and obtain new tubing and date it. In interview with RN 1 on 05/24/2024 at 10:32 AM, she stated she expected to find any resident's respiratory tubing properly stored in a bag or on the resident. RN 1 stated if the tubing was found anywhere else, she would change out the tubing, date the new tubing, and place it in a bag. She stated all tubing was to be dated to ensure other nurses were aware of the changing of the tubing and know when it was to be changed again. RN 1 stated the risk to residents wearing tubing which had been lying on the floor or lying uncovered on a shelf was the residents could breathe in bacteria, which could lead to the spread of infections such as pneumonia's. In interview with Certified Nursing Assistant (CNA) 7 on 05/24/2024 at 10:46 AM, she stated any oxygen tubing,C-PAP, or BiPap tubing was to be stored in a bag when not in use to prevent the spread of infection. CNA 7 stated she told the nurse whenever she saw uncovered (respiratory) tubing, so the nurse could dispose of that tubing. She stated the risk for the residents wearing tubing which had been uncovered was the risk of spreading infections and the growing of bacteria, which could get into the lungs of the residents. In interview with the Assistant Director of Nursing (ADON) on 05/24/2024 at 12:56 PM, she stated she expected to find all respiratory tubing, whether it was oxygen tubing, C-PAP, or BiPap tubing, to be stored in a bag or the resident wearing it. The ADON stated the tubing, when not in use, was to be stored in a bag to protect it from bacteria. She stated her expectation was if a resident's tubing was found lying on the floor, lying on the bed, or lying on a shelf uncovered, for her nursing staff to throw that tubing away and obtain new tubing which was to be labeled and placed in a bag. The ADON stated the risks for residents wearing tubing that was unprotected (not stored in a bag) was the risk for increased infections such as pneumonia's, which could lead to hospitalization s and ultimately death if the resident was severely compromised. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In interview with the Director of Nursing (DON) on 05/24/2024 at 1:10 PM, she stated her expectation was for residents to be wearing respiratory tubing which had been stored appropriately. The DON stated she also expected any respiratory tubing which had been compromised, to be disposed of by nursing staff, with new tubing obtained and dated and stored in a bag to prevent the spread of infections. She stated the risks for residents wearing the unprotected, contaminated tubing, whether it was oxygen tubing or BiPap tubing, was the spread of bacteria which could lead to respiratory infections such as pneumonia, re-hospitalization s for residents, or the need for antibiotic therapies for compromised residents. She stated her expectation was for her nurses to be observant when making rounds to ensure the residents' respiratory tubing was properly placed in a bag. She also stated she expected the nurses to either change residents' tubing and/or clean the filters at any time if needed regardless of the due dates for tubing changes. The DON stated it was ultimately the responsibility of her nurses to ensure the residents had clean respiratory equipment. She further stated if the nurses did not perform their job duties as required, then she would re-educate them and give disciplinary action for continued failure to perform their job duties. In interview with the Administrator on 05/24/2024 at 1:25 PM, he stated he expected the nursing staff to be making rounds to ensure residents' respiratory equipment was properly stored when not in use to prevent the spread of bacteria. The Administrator stated regardless of who was supposed to clean the equipment or change the tubing, it was ultimately up to nursing staff to ensure the residents' tubing was clean and stored in a bag when not in use. He further stated if a resident was wearing tubing which had been uncovered and/or lying on the floor, it could lead to the spread of infection, and put the resident at risk for increased lung infections.